215 ILCS 5/364.01 Qualified Clinical Cancer Trials

Sec. 364.01. Qualified clinical cancer trials.

(a) No individual or group policy of accident and health insurance issued or renewed in this State may be cancelled or non-renewed for any individual based on that individual's participation in a qualified clinical cancer trial.

(b) Qualified clinical cancer trials must meet the following criteria:

(1) the effectiveness of the treatment has not been determined relative to established therapies;

(2) the trial is under clinical investigation as part of an approved cancer research trial in Phase II, Phase III, or Phase IV of investigation;

(3) the trial is:

(A) approved by the Food and Drug Administration; or

(B) approved and funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the United States Department of Defense, the United States Department of Veterans Affairs, or the United States Department of Energy in the form of an investigational new drug application, or a cooperative group or center of any entity described in this subdivision (B); and

(4) the patient's primary care physician, if any, is involved in the coordination of care.

(c) No group policy of accident and health insurance shall exclude coverage for any routine patient care administered to an insured who is a qualified individual participating in a qualified clinical cancer trial, if the policy covers that same routine patient care of insureds not enrolled in a qualified clinical cancer trial.

(d) The coverage that may not be excluded under subsection (c) of this Section is subject to all terms, conditions, restrictions, exclusions, and limitations that apply to the same routine patient care received by an insured not enrolled in a qualified clinical cancer trial, including the application of any authorization requirement, utilization review, or medical management practices. The insured or enrollee shall incur no greater out-of-pocket liability than had the insured or enrollee not enrolled in a qualified clinical cancer trial.

(e) If the group policy of accident and health insurance uses a preferred provider program and a preferred provider provides routine patient care in connection with a qualified clinical cancer trial, then the insurer may require the insured to use the preferred provider if the preferred provider agrees to provide to the insured that routine patient care.

(f) A qualified clinical cancer trial may not pay or refuse to pay for routine patient care of an individual participating in the trial, based in whole or in part on the person's having or not having coverage for routine patient care under a group policy of accident and health insurance.

(g) Nothing in this Section shall be construed to limit an insurer's coverage with respect to clinical trials.

(h) Nothing in this Section shall require coverage for out-of-network services where the underlying health benefit plan does not provide coverage for out-of-network services.

(i) As used in this Section, "routine patient care" means all health care services provided in the qualified clinical cancer trial that are otherwise generally covered under the policy if those items or services were

not provided in connection with a qualified clinical cancer trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial. "Routine patient care" does not include, and a group policy of accident and health insurance may exclude, coverage for:

(1) a health care service, item, or drug that is the subject of the cancer clinical trial;

(2) a health care service, item, or drug provided solely to satisfy data collection and analysis needs for the qualified clinical cancer trial that is not used in the direct clinical management of the patient;

(3) an investigational drug or device that has not been approved for market by the United States Food and Drug Administration;

(4) transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with the travel to or from a facility providing the qualified clinical cancer trial, unless the policy covers these expenses for a cancer patient who is not enrolled in a qualified clinical cancer trial;

(5) a health care service, item, or drug customarily provided by the qualified clinical cancer trial sponsors free of charge for any patient;

(6) a health care service or item, which except for the fact that it is being provided in a qualified clinical cancer trial, is otherwise specifically excluded from coverage under the insured's policy, including:

(A) costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for the fact that the insured is participating in the cancer clinical trial; and

(B) costs of nonhealth care services that the patient is required to receive as a result of participation in the approved cancer clinical trial;

(7) costs for services, items, or drugs that are eligible for reimbursement from a source other than a patient's contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the approved cancer clinical trial; or

(8) costs associated with approved cancer clinical trials designed exclusively to test toxicity or disease pathophysiology, unless the policy covers these expenses for a cancer patient who is not enrolled in a qualified clinical cancer trial; or

(9) a health care service or item that is eligible for reimbursement by a source other than the insured's policy, including the sponsor of the qualified clinical cancer trial.

The definitions of the terms "health care services", "Non-Preferred Provider", "Preferred Provider", and "Preferred Provider Program", stated in 50 IL Adm. Code Part 2051 Preferred Provider Programs apply to these terms in this Section.

(j) The external review procedures established under the Health Carrier External Review Act shall apply to the provisions under this Section.

215 ILCS 5/356z.16. Applicability of mandated benefits to supplemental policies.

Unless specified otherwise, the following Sections of the Illinois Insurance Code do not apply

to short-term travel, disability income, long-term care, accident only, or limited or specified disease policies: 356b, 356c, 356d, 356g, 356k, 356m, 356n, 356p, 356q, 356r, 356t, 356u, 356w, 356x, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.12, 364.01, 367.2-5, and 367e.

(Source: P.A. 96-180, eff. 1-1-10; 96-1000, eff. 7-2-10; 96-1034, eff. 1-1-11.)

215 ILCS 125/5-3 Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

215 ILCS 165/10 Application of Insurance Code provisions.

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 364.01, 367.2, 368a, 401,401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 93-1000, eff. 1-1-05; P.A. 97-0091, eff. 1-1-12)